EASTERN HEALTH BOARD

Minutes of proceedings of Monthly Meeting held in the Boardroom, Dr. Steevens' Hospital, on Thursday 14th December, 1995 at 6.00 p.m.

Present

Mr. P. Aspell
Mrs. B. Bonar
Cllr. E. Byrne. T.D.
Cllr. B. Coffey
Cllr. T. Cullen
Dr. J. Fennell
Dr. R. Hawkins
Cllr. T. Keenan
Cllr. M. McWey
Cllr. D. O'Callaghan
Cllr. C. O'Connor
Dr. J. Reilly
Sen. D. Roche
Cllr. R. Shortall, T.D.
Cllr. D. Tipping
Dr. M. Wrigley
Cllr. M. Barrett
Cllr. G. Brady
Cllr. I. Callely, T.D.
Cllr. J. Connolly
Cllr. A. Devitt
Cllr. C. Gallagher
Dr. D.I. Keane
Mr. G. McGuire
Cllr. O. Mitchell
Cllr. Dr. W. O'Connell
Cllr. J. Reilly
Cllr. T. Ridge
Cllr. K. Ryan
Dr. C. Smith
Cllr. M. Whitty

Apologies

Ms. M.Nealon

In the Chair

Cllr. M. Barrett

Officers in Attendance

Mr. K. J. Hickey, Chief Executive Officer
Mr. P.J. Fitzpatrick, Programme Manager. Community Care
Mr. S. O'Brien, A/Programme Manager. General Hospital Care
Mr. M. Walsh, Programme Manager, Special Hospital Care
Mr. M. Gallagher. Finance Officer
Ms. M. Kelly, Personnel Officer
Dr. B. O'Herlihy, Director of Public Health
Mr. J. Curran, A/Technical Services Officer
Ms. M. Browne. Communications Director
Mr. P. Doyle. Estate Management Officer
Mr. M. O'Connor, Secretary

140/1995
CONDOLENCES

On the proposal of the Chairman votes of sympathy were passed with:-

- Deputy Roisin Shortall on the death of her brother.
- Noel Bam. Community Welfare Service, on the death of his sister.
- Martin O'Donoghue. Community Welfare Service, on the death of his mother.
- Joan Brennan. Community Care Service, on the death of her father.
- Dr. Rosaleen Watters. Community Care Service, on the death of her father.

141/1995

CHAIRMAN'S BUSINESS

The Chairman read the following report which was noted by the Board:-

1. **January Meeting of Board**

I wish to remind members that the January meeting of our Board will be held on Thursday 11th January 1996.

2. **Future Organisational Structures in our Board's Area**

I have circulated with the agenda papers for this meeting, copies of letter dated 9th November. 1995 which I received from the Private Secretary to the Minister for Health. Members will note that during the preparation of the final legislative proposals, the particular issues raised by our Board can be addressed.

142/1995
MINUTES OF PROCEEDINGS OF MONTHLY MEETING HELD ON 2ND AND 7TH NOVEMBER, 1995 AND OF SPECIAL MEETINGS HELD ON 27TH JULY, 12TH OCTOBER, 19TH OCTOBER, 23RD OCTOBER AND 13TH NOVEMBER 1995.

The minutes of proceedings of the monthly meeting held on 2nd and 7th November, 199S and of the special meetings held on 27th July, 12th October, 19th October, 23rd October and 13th November, 1995, having been circulated, were confirmed on a proposal by Dr. Hawkins, seconded by Cllr. Dr. O'Connell.

|a] Matters arising from the minutes

Deputy Callely referred to minute no. 139/1995 regarding the review of services for the elderly and requested that the next special meeting of our Board to consider this matter should focus on services for the elderly with dementia, especially Alzheimers' patients.

143/1995
QUESTIONS TO THE CHIEF EXECUTIVE OFFICER

On a proposal by Mr. Aspell, seconded by Cllr. Ryan, it was agreed to answer the questions which had been lodged.

1. Cllr.T. Ridge

"To ask when the agreed renovations for Peamount Hospital will start."

Reply

The Department of Health has made available a capital allocation of £190,000 this year in respect of the redevelopment of St. Anne's Unit for the mentally handicapped (£160,000) and the refurbishment of sanitary facilities (£30.000) at Peamount Hospital. The latter work has been completed.

The redevelopment of St. Anne's Unit into two separate units for the elderly mentally handicapped is still at the planning stage.

2. Cllr. T. Ridge

"To ask for an update re. Clondalkin (Deansrath) Health Centre."

Reply

Our Board has recently concluded negotiations for the purchase of a number of units at the Neighbourhood Shopping Centre at Deansrath. A contract to purchase has been signed, subject to receipt of planning permission which will shortly be sought.

The Architect for the project is currently preparing preliminary sketch plans for the conversion works, on the basis of the approved brief. These will be completed shortly.

3. **Cllr. T. Ridge**

"To ask what is the cost to date of providing residential care at Killinarden House, Palmerstown."

Reply

The costs to end of November 1995 are as follows:

Capital costs (including building and original conversion and subsequent renovation. fire protection, furniture, fittings and security.)	£ 156.000

Cllr. R. Shortall, T. D.

"Will the Chief Executive Officer outline the procedure involved where a hospital outpatient who receives a prescription from a doctor must take that prescription to their own doctor who in turn rewrites the prescription in order that the medications qualify for medical card purposes. Will the Chief Executive Officer state why such an inconvenient and cumbersome system exists and if it would be possible to simplify this for patients and avoid hardship."

Reply

Medical Card patients issued with prescriptions at hospital outpatient clinics are required to return them to their registered General Practitioner. Under the terms of the General Medical Services Scheme, payment to Pharmacists will only issue on foot of prescriptions on the official G.M.S. prescription form which can only be written by a participating general practitioner.

The overall question of protocols governing hospital prescribing for out-patients is under review nationally, and the Department of Health has indicated that it is addressing a number of related issues in the context of improving co-operation and liaison between hospitals and general practitioners.

Cllr. E. Byrne, T.D.

"Will the Chief Executive Officer please explain the workings of the Eastern Community Works Projects and how this company can be accessed for work in the Crumiin/Drimnagh/Walkinstown area."

Reply

In 1982, the Government set up a special Task Force to improve the housing conditions of elderly people living alone in unsanitary or unfit accommodation. After an initial pilot phase our Board set up Eastern Community Works Ltd. in 1983 to carry out the work in respect of approved applications.

Applications are made to our Board by the occupant of the premises requiring improvement or by any person (eg. voluntary organisation, relative, public health nurse) on his/her behalf. Persons living in local authority housing are excluded under the scheme. The applications are assessed and, if approved, arrangements are made to have the necessary works carried out by Eastern Community Works Ltd. Approved work is carried out by four FAS Community Youth Training Programmes (CYTP) which cover most of the Dublin area. Work in Counties Kildare and Wicklow and in the remaining area of Dublin is carried out by contract. Applications for the Crumiin/Drimnagh/Walkinstown area should be made to the Area Administrator at the local Community Care Office in Old County Road, Crumlin.

Since early 1994. the Dublin south west area. which includes Crumiin/Drimnagh/Walkinstown has been without a CYTP scheme. Pending the establishment of a scheme, work on priority applications has been carried out by contract. FAS have now indicated that they are in a position to approve a scheme and the necessary arrangements, including the establishment of a training base for the trainees, are being put in place. The backlog of applications will be carried out by the new CYTP scheme and until all applications are cleared, also by contract.

Clir. B. Coffey

"Will the Chief Executive Officer contact the Department of Health with a view to a national distribution of their magazine 'Understanding Drugs'."

Reply

The Health Promotion Unit of the Department of Health has produced a leaflet entitled "Understanding Drugs - a guide for parents" - copy attached for the information of members.

Contact with the Department of Health has confirmed that, in addition to the distribution of this leaflet nationally to each of the health boards in 1992. requests for additional copies of the leaflet are regularly received from health promotion officers, schools and general practitioners.

The leaflet is available in our Board's customer services department, community drug centres and other locations such as health centres and hospitals. Arrangements are being made to ensure that stocks of the leaflet are available in all appropriate centres.

Cllr. B. Coffey

"What plans has the Eastern Health Board regarding a detoxification unit in the Dun Laoghaire area?."

Reply

Approximately one quarter of those who wish to undergo detoxification require in-patient facilities and three quarters can be dealt with successfully at out-patient level.

Our Board's proposals for 19% include the development of a community drug centre in Dun Laoghaire and out-patient detoxification is one of the range of services provided at such centres.

There are currently two in-patient detoxification units available, i.e. at Beaumont Hospital and the recently opened unit at Cherry Orchard Hospital. These in-patient detoxification units at present serve all areas, including Dun Laoghaire. The need for additional in-patient facilities is being kept under constant review.

Cllr. I. Callely, T.D.

"To ask the Chief Executive Officer to indicate the demand for Home Help Services in Area 7 and Area 8. will the Chief Executive Officer clarify how the scheme is administered and the name of the administrators in each area, can I be given a breakdown of the numbers in receipt of Home Help Services and Eastern Health Board expenditure in Area 7 and 8 for the years 1990 to 1995 and will he make a statement on the matter".

Reply

The demand for the Home Help Service in Area 7 and in Area 8 can best be measured in terms of the number of persons who are assisted under the scheme. There is a very limited

waiting list for the service. The scheme is administered by a number of voluntary organisations, who receive funding from our Board and who cover a specific catchment area. Each Home Help Organisation engages a Home Help Organiser. Referrals for services, which are made to the Organiser are mainly from Public Health Nurses, General Practitioners, hospitals and relatives.

The number of persons assisted, and the expenditure involved for each of the years 1990 to 1995. and the Home Help Organisations administering the scheme are as follows:

Number assisted

YEAR	Area 7	Area 8
1990	1.180	642
1991	1.227	652
1992	1.153	645
1993	1.189	650
1994	1,250	684
1995	1,245(E)	702(E)

Expenditure

1990	£651,800	£390,000
1991	£724,890	£545,000
1992	£743,720	£555,000
1993	£742,500	£555,000
1994	£788,135	£580,000
1995	£790,000 (E)	£620,000 (E)

Area/Parish covered bv each Organisation

AXBLZ

Area/Parish	Organisation	Organiser to be Contacted	Telephone No.
Drumcondra, Fairview. Glasnevin, Iona Road. Larkhill. Marino, Whitehall	Drumcondra Old Folks Association. c/o 15 Walnut Rise, Griffith Avenue. Dublin 9	Mrs. B. Power Mrs. J. Malone	8373525 8373796
Berkeley Road. Gardiner Street	Our Lady of Lourdes Social Service Centre. 28 Upper Sherrard Street	Mrs. M. Donohue	8740439
Ballybough. North Strand. Our Lady of Lourdes. Pro Cathedral	Our Lady of Lourdes. Social Service Centre. Lr. Sean McDermott Street	Sr. Helen McEvilly Ms. E. Doyle	8787770
North Wall. East Wall	St. Laurence OToole. Social Service Centre, c/o Community Centre. East Wall	Mrs. M. Brady	8743603

Donnycarney. Beaumont. Fairview. Marino	Donnycarne\/Beaumont. Social Service Centre. c/o Coolatree Road. Beaumont	Mrs. M. Cribbon	8333421 8337109
Clontarf/Killester	Clontarf Home Help Service. St. Gabriels Road. Clontarf	Ms. M. Lzell	8331935
Balcurris. Ballymun. Ballymun Road. Stillogan	Little Sisters of the Assumption, c/o 23 Shangan Road. Ballymun. Dublin 9	Sr. Catherine Dunphy. Ballymun Health Centre	8420011

Area_8

Area/Parish	**Organisation**	**Organiser to be contacted**	**Telephone No.**
Edenmore. Ki Hester. Raheny	Killester Social Service Council, Svbill Hill Road	Mrs. C. Colgan	8313700
Ayrfield. Baldoyle. Donaghmede. Foxfield. Portmarnock	Kilbarrack Home Help Organisation, Kilbarrack Health Centre.	Mrs. P. Towers	8391221
Bonnybrook, Darndale, Priorswood, Part of Coolock, Ardiea Road, Kilmore West	Darndale/Kilmore Home Help Committee. Coolock Health Centre.	Mrs. A. Sexton	8476122 8476033
Bayside. Howth. Sutton	Howth Home Help Committee, c/o Howth Health Centre	Ms. N. Breslin	8322984
Swords, Brackenstown. Donabate. Garristown. Tinselly. Rochestown. The Naul	Swords Home Help Committee, 2 Church Road, Swords	Mrs. A. McShorthall	8401533
Balbriggan	Balbriggan Home Help Committee, c/o Health Centre	Mr. P. Bamett	8413196
Skerries, Rush. Lusk	Skerries Home Help Committee, c/o Health Centre	Mrs. B. Gavin	8491367

Cllr.I.Callely,T.D.

'To ask the Chief Executive Officer the total number of psychiatric long-stay patients resident in our psychiatric hospitals in the Eastern Health Board catchment area at present, can the Chief Executive Officer give a comparison figure for 1990,1985, 1980 and 1975, will the Chief Executive Officer advise what studies/research has shown the actual number of long-stay psychiatric beds required and will he make a statement on the matter".

Reply

The numbers of long stay patients in our Board's Psychiatric Hospitals for the years requested are set out hereunder:-

Hospital	1995	1990	1985	1980	1975
St. Loman's Hospital	25	54	57	67	74
Newcastle Hospital	36	36	37	32	N/A
St. Ita's Hospital	248	329	448	541	555
St. Brendan's Hosp	161	273	730	N/A	N/A

The in-patient population in psychiatric hospitals/units has reduced by just over 1.000 in the last ten years, while 1.300 alternative beds/accommodation have been provided in the community.

Research on new long stay patients in the Eastern Health Board area was carried out in 1992 and 1994. Reference "New Long Stay Patients" (Drs. Gannon, Johnson. Meagher, Hussen and Farren. 1992) and "A Follow up Study of New Long Stay Patients" (Drs. Gannon. Meagher and Watters. 1994). These studies give a clear indication of overall needs within the region and demonstrate that a steady state exists between those becoming new long stay and those leaving the in patient services.

Cllr. I. Callely T.D.,

"To ask the Chief Executive Officer the waiting period for results from the processing of smear tests, can the Chief Executive Officer advise if smear and other screening measures are adequate and successful and will he make a statement on the matter".

Reply

Smears are taken by General Practitioners, by doctors at Family Planning Clinics, by Gynaecologists in hospitals and in their own practices, and by Public Health Nurses in some of our Board's Clinics.

Cervical smears are processed mainly at St. Luke's Hospital. The interval between the taking of a smear and the issue of the result is up to two weeks which is regarded by professionals as reasonable and acceptable.

Cllr. J. Reilly.

"To ask the Chief Executive Officer to give details in relation to the following: -|a] to state the number of Home Helps currently engaged by this Board in Area 9 (Kildare) [b] the criteria by which applications are sought, decided on, and appointments made |c] the annual cost of this service in Area 9 for each of the past three years."

Reply

(a) The number of Home Helps currently engaged by our Board in Area 9, (Kildare) is 479.

(b) Requests for home help service are made by persons needing home help, by their relatives, by our Board's field staff including public health nurses and social workers, by general practitioners and by hospitals. Requests/applications for north of the county are assessed by our Board's Home Help Organiser and for south of the county by the Public Health Nursing Service. Decisions on applications are made by the local Area Home Help Committee, which comprises the Administrator. Superintendent Public Health Nurse and Home Help Organiser. Appointments are made as appropriate through the local Community Welfare Officer. When assessing applications regard is taken of the applicant's degree of illness/debility, domestic circumstances, extended family availability, ability- to pay and any other relevant circumstances.

(c) The annual cost of this service in Area 9 for each of the past three years is as follows:

1992	**1993**	**1994**
£448.858	£542,801	£553,324

Cllr. C. O'Connor

"To ask the Chief Executive Officer if he has considered 'Here. There and Nowhere", the recently published study of youth homelessness in Tallaght and if he will arrange to assist the Tallaght Homeless Advice Unit and respond to the recommendations."

Reply

We are at present considering the recently published study of youth homelessness in Tallaght. entitled "Here. There and Nowhere". The recommendations in the report are being considered in the context of the formulation of an overall plan for youth homelessness for our Board's area.

Within the past month, meetings have taken place between officials of our Board and representatives of the Tallaght Homeless Advice Unit in relation to both youth and adult homelessness.

Cllr. C. O'Connor

"To ask the Chief Executive Officer to state when he expects the planned Health Centres in Tallaght to open and will he update the Board in the matter."

Reply

Our Board's Capital Development Plan for Health Centres provides for the construction of a major centre at Fortunestown and two smaller centres in association with G.P. practices at Killinarden and Rossfield.

Our Board's Technical Services Officer and the G.P. Unit are overseeing the development of the Killinarden and Rossfield Centres, and a schedule has been agreed which envisages completion by the end of 1996.

The Schedule drawn up for the Fortunestown Centre envisages completion by the end of 1997.

14. Cllr. C. O'Connor

'To ask the Chief Executive Officer to update the Board on recent dealings with the local community regarding Eastern Health Board houses in Main Street and Main Road. Tallaght. and will he make a general statement in the matter."

Reply

Meetings have been held with local residents and with local representatives of our Board regarding 15 and 16 Main Road. Tallaght following which our intended use of both properties was set out in writing to the Secretary of the Residents' Association. In addition, continued liaison arrangements were offered to the Secretary of the Residents' Association.

In relation to no. 515 Main Street. Tallaght we have received several telephone enquiries and one written enquiry as to its intended use. All enquiries have been fully addressed and reassurances given as to the intended use of the premises."

144/1995
CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer read the following report which was noted and agreed subject to the comments recorded below:-

1. Christmas Bonus Payment for Foster Children and Children placed with Relatives

I have circulated with the agenda papers for this meeting copies of letter dated 3rd November, 1995 from the Department of Health giving details of a Christmas Bonus payment for foster children and children placed with relatives.

2. Extra payment of Maintenance Allowances for one week in December

I have circulated with the agenda papers for this meeting copies of letter dated 7th November, 1995 from the Department of the Health giving details of an additional payment to recipients of long-term maintenance allowances for one week in December 1995.

3. National Task Force on Suicide

I have circulated with the agenda papers for this meeting copies of a Press Release issued by the Minister for Health regarding the setting up of a National Task Force on Suicide.

4. Tax on Cigarettes

I have circulated with the agenda papers for this meeting copies of letters from the Department of Health and the Department of Finance in response to the Community Care Programme Committee's resolution regarding the placing of a penny tax on cigarettes to fund the cost of health promotion programmes.

The Department of Health letter indicates that, in their pre-budgetary submissions to the Minister for Finance, they encourage the maintenance of the appropriate levels of excise duty on tobacco products.

The letter from the Department of Finance states that it is not the policy to earmark taxes for specific expenditure proposals and that the merits of expenditure for health promotion activities is a matter for consideration in the context of the setting of the annual Estimates of Public Expenditure.

5. Resolution from County Kildare Vocational Education Committee

I have circulated with the agenda papers for this meeting copies of letter dated 15th November 1995 from the County Kildare Vocational Education Committee seeking support for their resolution relating to the Government White Paper on Education.

6. New Immunisation Scheme

I have circulated with the agenda papers for this meeting copies of a Press Release issued by the Minister for Health welcoming the successful conclusion of negotiations between the Irish Medical Organisation and the Department of Health on the introduction of a new national scheme to deliver Primary Childhood Immunisation through General Practitioners.

The new scheme will involve contract holding general practitioners in close working arrangements with the Department of Public Health in each health board and it is expected that with commitment and co-operation, the uptake level of 95% of the target population should be achieved.

The new scheme is being introduced with immediate effect.

7. Voluntary Health Insurance (Amendment) Bill, 1995

I have circulated with the agenda papers for this meeting copies of a press release issued by the Minister for Health when he announced the publication of the Voluntary Health Insurance (Amendment) Bill, 1995.

8. Health Fact Sheet 4/95

I have circulated with the agenda papers for this meeting, copies of a Health Fact sheet on health expenditure in Ireland which updates selected information on public and private health spending to September 1995.

9. Medical Card Guidelines

I have circulated this evening for the information of members, copies of the guidelines for the issue of medical cards which have been revised with effect from 1st January 1996.

10. Election of Dr. Don Keane as President of the Dental Council

I am sure members will join with me in congratulating our Board's Dental Adviser. Dr. Don Keane, on his recent re-election as President of the Dental Council.

11. Post of Superintendent Physiotherapist, Royal City of Dublin Hospital, Baggot Street

I have circulated this evening, copies of my Report regarding the proposed abolition of the post of Superintendent Physiotherapist Royal City of Dublin Hospital, Baggot Street to enable me to apply the provisions of Article 10 of the Superannuation Revision (Consolidation) Scheme to the holder, who agrees with this course of action.

On a proposal by Cllr. Coffey, seconded by Deputy Callely, it was agreed to abolish the post of Superintendent Physiotherapist, Royal City of Dublin Hospital. Baggot Street.

145/1995
TALLAGHT HOSPITAL GROUP

The following Report No. 44/1995 from the Chief Executive Officer was submitted.

"Our Board is currently represented on the existing Tallaght Hospital Board by:-

* Cllr. Ben Briscoe T.D.
* Cllr. Thomas Cullen
* Mr. Seamus O'Brien. Programme Manager. General Hospital Care

I attach a copy of letter dated 3rd November from the Minister for Health to the Chairman of our Board with which he enclosed a copy of his letter to the Chairmen of the three base hospitals transferring to the new hospital in Tallaght, setting out proposals designed to allow a management structure for the new hospital to be put in place as speedily as possible.

The Minister proposed that the hospitals transferring to Tallaght should put in place a group, being the Board designate, founded on the principles agreed in the revised charter which would have the consent of all parties with a nominating right to the new Tallaght Board. On the basis that the arrangements set out meet with our Board's approval the Minister requests that the name of our Board's nominee, who would become a member of the Board once the Charter for me new Hospital is enacted, should be forwarded to him as soon as possible.

The nomination of such a person is a matter for our Board.

I have been advised by the Programme Manager, General Hospital Care, that the Board of the Meath Hospital has nominated the following members of our Board to die Group who will become members of die Tallaght Hospital Board once the Charter for the new Hospital is enacted:-

- Cllr. Gerry Brady
  Cllr. Tom Keenan
- Cllr. Kevin Ryan"

Cllr. Charles O'Connor was proposed by Deputy Callely and seconded by Cllr. Dr. O'Connell. Cllr.

Therese Ridge was proposed by Cllr. Mitchell and seconded by Cllr. Devitt.

On a show of hands, Cllr. O'Connor was nominated. Cllr. O'Connor thanked the members who had supported him in the election.

146/1995

CHILD CARE ADVISORY COMMITTEE

Report no. 45/1995

Chief Executive Officer was submitted (copy filed with official minute).

Having noted and agreed the Report, the following three members of our Board were nominated to be members of the Child Care Advisory Committee:

Cllr. I. Callery T.D. (Chairman)
Mr. G. McGuire (Vice-Chairman)
Dr. J. Reilly

147/1995
CHILD CARE ADVISORY COMMITTEE

Report no. 46/1995 from Mr. P J. Fitzpatrick, Programme Manager, Commnnity Care Service was submitted (copy filed with official minute).

On a proposal by Deputy Callely, seconded by Cllr. Dr. O'Connell, it was agreed to note the Report and to refer it to the Community Care Programme Committee for further consideration.

148/1995
DRUGS SERVICES - DEVELOPMENT PLANS FOR 1996

Report no. 47/1995 from the Chief Executive Officer was submitted (copy filed with official minute)

During a discussion to which Deputy Byrne, Cllr. Coffey, Deputy Shortall, Cllr. O'Callaghan, Senator Roche, Cllr. Connolly, Cllr. Mitchell and Deputy Callely contributed, members, in recognising the difficulties encountered by our Board throughout the development of community drug centres, emphasised the importance of consultation with them, and with other public representatives, in relation to plans and proposals for the development of services so that negotiations/consultations with local communities could be facilitated and public representatives could be in a better position to support the Health Board in its efforts to develop community based facilities.

The remainder of the business was adjourned to the January meeting of our Board.

The meeting concluded at 7.30 p.m.

CORRECT: **K J. HICKEY**
CHIEF EXECUTIVE OFFICER

EASTERN HEALTH BOARD

Report No. 45/1995

Child Care Advisory Committee - Membership

The directions of the Minister for Health in 1992 in relation to Child Care Advisory Committees provided that the first appointment of members of a Child Care Advisory Committee should be for the period ending 31st December, 1995 and that subsequent such appointments should be for a period of not exceeding three years.

The membership of the Child Care Advisory Committee shall include:-

[i] three members of our Board and

[ii] others as outlined in the following paragraphs:-

In accordance with paragraph 2 [b] of the Minister's directions I am nominating the following three officers of our Board for appointment for the period ending 31st December 1998:-

[a]	Public Health Medicine:	Dr. Davida De La Harpe, A/ Director of Community Care & Medical Officer of Health
[b]	Public Health Nursing:	Ms. Sheila O'Malley, Superintendent Public Health Nurse
[c]	Social Work:	Ms. Olga Garland, Head Social Worker

In accordance with paragraph 3 of the directions and following consultation with the appropriate bodies, I recommend that the following persons/representatives should also comprise the membership of the Committee from 1st January, 19th to 31st December, 1998:-

Not more than nine persons including representatives of voluntary bodies involved in the provision of the following services:*

[a] Adoption and Foster Care Services:

Ms. Pat Whelan, Irish Foster Care Association Ms. Marilyn Roantree, Head Social Worker

[b] Residential Care Services:

Ms. Mary O’Connell, Chairperson, Tabor Society

[c] Services for pre-school children:

Ms. Peggy Walker, Irish Pre-School Playgroups Association

[d] Services for homeless children

Sr. Catherine Prendergast, Daughters of Charity of St. Vincent de Paul

[e] Child and adolescent psychiatric services:

Dr. Paul McCarthy, Clinical Director, Child Psychiatry

[f] Support services for children and their families:

Mr. Owen Keenan, Dr. Barnados Ms. Margaret Dromey,
Treoir

and the following nominees as provided for in the directions:-

* **Mr. David O'Donovan, A/Principal, Probation and Welfare Service, Department of Justice.**

* **a member of the Garda Siochana nominated by the Garda Commissioner**

* **a representative of Education nominated by the Department of Education**

Nominations have been sought from the Garda Commissioner and from the Department of Education.

Co-option of Members:

The Child Care Committee may co-opt not more than three other persons in accordance with paragraph 14 of the directions.

Secretary:

Mr. Ray Kavanagh, Senior Executive Officer, will continue to act as Secretary to the Committee.

The nomination of the three members of our Board, and the appointment of the Chairman and Vice-Chairman of the Committee from among those three members, is a matter for our Board.

K J.Hickey,
Chief Executive Officer **24th November, 1995**

XX 1

Section 7 of the Child Care Act. 1991

Directions of the Minister for Health in relation to Child Care Advisory Committees

Membership

A child care advisory committee shall be composed of not more than 20 persons with a special interest or expertise in matters affecting the welfare of children, including representatives of voluntary bodies providing child care and family support services.

The membership of a child care advisory committee shall consist of -

(a) three members of the health board who shall be nominated by the health board;

(b) three officers of the health board, one each from the following disciplines, who shall be nominated by the chief executive officer -

(i) public health medicine,

(ii) public health nursing,

(iii) social work;

(c) not more than nine persons, including representatives of yoluntary bodies involved in the provision of any, of the following services -

(i) adoption and foster care services,
(ii) residential care services,
(iii) services for pre-school children,
(iv) educational services,
(v) services for homeless children,
(vi) child and adolescent psychiatric services,
(vii) support services for children and their families;

(d) a representative of the Probation & Welfare Services of the Department of Justice nominated by that Service;

(e) a member of the Garda Siochana nominated by the Garda Commissioner;

(f) not more than three other persons whom the committee may co-opt in accordance with paragraph 14 of these directions.

The chief executive officer shall, after consultation with appropriate bodies, make recommendations to the health board in relation to the appointment of the persons mentioned in paragraph 2(c) of these directions and the health board shall have regard to such recommendations.

Chairman and Vice-chairman

The chairman and vice-chairman of a child care advisory committee shall be appointed by the health board from among the three members of the health board nominated to the committee.

Term of Office

The first appointments by the health board of members of a child care advisory committee shall be for the period ending on 31 December, 1995 and subsequent such appointments shall be for a period not exceeding three years.

Every member of a child care advisory committee other than a member who was co-opted shall hold office (unless he sooner dies, resigns or becomes disqualified) until the day after his successor has been appointed.

An outgoing member of a child care advisory committee may be reappointed.

Resignation and Termination of Membership

A member of a child care advisory committee may resign his membership by letter addressed to the chief executive officer and the resignation shall take effect as and from the date of receipt of the letter by the chief executive officer.

The membership of a person appointed by virtue of his holding a particular appointment or having a particular qualification shall terminate if he ceases to hold that appointment or have that qualification.

The health board shall, if so requested by a person or body on whose nomination a person was appointed to be a member of a child care advisory committee, terminate the appointment of that member and appoint a replacement nominated by the person or body concerned.

The health board may remove from office any member of a child care advisory committee who, in the opinion of the board, has become incapable through ill-health of effectively performing his or her functions, or who has committed stated misbehaviour, or whose removal appears to the board to be necessary for the effective performance by the committee of its functions.

Casual Vacancies

The health board may appoint a person to fill a casual vacancy occurring among the members of a child care advisory committee, subject to the provisions which governed the appointment of the person whose cessor of membership caused the vacancy.

- **A person appointed to fill a casual vacancy shall hold office for the remainder of the term of office of the committee.**

Co-option of Members

14. A member of a child care advisory committee may nominate a person to be co-opted as a member of the committee and that person shall be co-opted if the nomination is approved by a majority of the members present at a meeting of the committee.

15. A member who is co-opted shall hold office for such period not exceeding the remainder of the term of office of the committee by which he was co-opted as that committee may specify.

Secretary

16. The secretary of a child care advisory committee shall be a person appointed by the chief executive officer.

Meetings

17. The first meeting of a child care advisory committee shall be held on a day to be appointed by the health board.

18. A child care advisory committee shall hold four meetings in each year and such other meetings as may be approved or requested by the health board.

19. The quorum for a meeting of a child care advisory committee shall be five members.

20. Meetings of a child care advisory commmittee shall be held in private.

21. The chief executive officer or his nominee shall be entitled to attend and address a meeting of a child care advisory committee.

Every request by a child care advisory committee for -

(a) the attendance of an officer of -the health board at a meeting of the committee, or

(b) non-personal information in relation to child care and family support services in the functional area of the health board,

shall be made to the chief executive officer or his nominee.

Proceedings at Meetings

The proceedings of a child care advisory committee shall not be invalidated by the existence of one or more vacancies in its membership or by any defect in the appointments to the committee or in the qualification of any member of the committee.

The chairman or, in his absence, the vice-chairman of a child care advisory committee may call a meeting of the committee.

If the chairman or, in his absence, the vice-chairman of a child care advisory committee refuses to call a meeting of the committee after a requisition for that purpose, signed by five members of the committee, has been presented to him, any five members of the committee may forthwith call a meeting and if the chairman or vice-chairman (without so refusing) does not, within seven days after the presentation of the requisition, call a meeting of the committee, any five members of the committee may, on the expiration of those seven days, call a meeting of the committee.

Three clear days at least before any meeting of a child care advisory committee, a summons to attend the meeting, specifying the business proposed to be transacted thereat and signed by the secretary of the committee, shall be left

or delivered by post at the usual place of abode of every member of the committee, but failure so to leave or deliver such summons for or to a member or some of the members of the committee shall not affect the validity of a meeting.

27. **No business shall be transacted at a meeting of a child care advisory committee other than that specified in the summons relating thereto.**

28. **At a meeting of a child care advisory committee -**

(a) **the chairman of the committee shall, if he is present, be chairman of the meeting,**

(b) **if and so long as the chairman of the committee is not present or the office of chairman is vacant, the vice-chairman shall, if he is present, be chairman of the meeting.**

(c) **if and so long as the chairman of the committee is not present or the office of chairman is vacant and the vice-chairman is not present or the office of vice-chairman is vacant, the members of the committee who are present shall choose one of their number to be chairman of the meeting.**

29. **Minutes of the proceedings of a meeting of a child care advisory committee shall be drawn up and entered in a book kept for that purpose and shall be signed by the chairman ; of the meeting or of the next ensuing meeting.**

30. **The names of the members present at a meeting of a child care advisory committee shall be recorded in the minutes of the proceedings of the meeting.**

31. **The names of the members voting on any question arising at a meeting of a child care advisory committee shall, if any member so requests, be recorded in the minutes of the proceedings of the meeting and the record shall show which**

members voted for and which against the question.

32. **All acts of a child care advisory committee and all questions coming or arising before the committee may be done and decided by the majority of such members of the committee as are present and vote at a meeting of the committee duly held in accordance with these directions.**

33. **In case of equality of votes on any question arising at a meeting of a child care advisory committee, the chairman of the meeting shall have a second or casting vote.**

34. **Subject to the provisions of section 7 of the Child Care Act, 1991, and of these directions, a child care advisory committee may, with the approval of the health board, make standing orders for the regulation of its proceedings and amend or revoke such standing orders.**

Advice of Committee

35. **The advice of a child care advisory committee shall be transmitted in writing to the chief executive officer who shall submit it to the health board for consideration.**

36. **The advice of a child care advisory committee shall be confidential until such time as it has been considered by the health board.**

Appendix 2

Child Care Advisory Committee
Eastern Health Board

Board members:
Cllr Ivor Callely TD (Chairperson)
Cllr Roisin Shortall TD (Vice-Chairperson)
Dr James Reilly

Officers:
Dr Sheila Lynch, Director of Community Care & Medical Officer of Health
Ms Stasia Cody, Supt Public Health Nurse
Ms Brid Clarke, Head Social Worker

Adoption and Foster Care Services:
Mr John Lysaght, Irish Foster Care Association
Ms Mary O'Hagan, Senior Social Worker

Residential Care:
sister Anne O'Neill, Daughters of Charity of St Vincent de Paul

Services for preschool children:
Ms Peggy Walker, Irish Pre-School Playgroups Association

Education services:
Mr Sean Hunt, Deputy Chief Inspector, Department of Education

Services for homeless children:
Ms Maureen Lynott, Focus Point
Ms Mary O'Connell, Chairperson, Tabor Society

Child and adolescent psychiatric services:
Dr Paul McCarthy, Clinical Director, Child Psychiatry

Support services for children and their families:
Ms Margaret Dromey, Federation of Services for Unmarried Parents and their Children

Probation and Welfare Service:
Mr David O'Donovan, A/Principal, Probation and Welfare Service, Department of Justice

Garda Siochana:
Inspector Mary Fitzgerald

Co-option:
Mr Robbie Gilligan, Social Studies Department, Trinity College

EASTERN HEALTH BOARD

Report No. 4671995

Child Care Advisory Committee

Our Board established a Child Care Advisory Committee in accordance with Section 7 of the Child Care Act 1991. Its purpose is to advise our Board on the performance of its functions under the legislation. The membership of the Committee (Appendix 1) ensures that the various branches of the child care services, including voluntary organisations and the child care professions, are represented.

Our Board's Advisory Committee met on eight occasions during 1995. The Committee decided to concentrate on providing advice to our Board in relation to the following two specific areas:-

1. **Teenage Pregnancy/Adoption**
2. **Children in Care**

Two sub-committees were established to consider and submit reports on these areas. The reports of the sub-committees were approved by the Committee in November 1995 for transmission to our Board. Copies of the reports are attached (Appendix 2).

As the term of office of the present Committee expires on the 31st December 1995 I wish to express my appreciation to all the members for their participation and work over the past three years. The advice in the attached reports, together with the report submitted in 1994, will be very helpful to all our staff involved in the planning and provision of Child Care and Family Support Services.

P J. Fitzpatrick
Programme Manager Community Care

5th December 1995

Appendix 1

Child Care Advisory Committee
Eastern Health Board

Board members:
Cllr Ivor Callely TD (Chairperson)
Cllr Roisin Shortall TD (Vice-Chairperson)
Dr James Reilly

Officers:
Dr Sheila Lynch, Director of Community Care & Medical Officer of Health
Ms Stasia Cody, SupL Public Health Nurse
Ms Brid Clarke, Head Social Worker

Adoption and Foster Care Services:
Mr John Lysaght, Irish Foster Care Association
Ms Mary O'Hagan, Senior Social Worker

Residential Care:
Sister Anne O'Neill Daughters of Charity of St Vincent de Paul

Services for preschool children:
Ms Peggy Walker, Irish Pre-School Playgroups Association

Education services:
Mr Sean Hunt, Deputy Chief Inspector, Department of Education

Services for homeless children:
Ms Maureen Lynott, Focus Point
Ms Mary O'ConnelL Chairperson, Tabor Society

Child and adolescent psychiatric services:
Dr Paul McCarthy, Clinical Director, Child Psychiatry

Support services for children and their families:
Ms Margaret Dromey, Federation of Services for Unmarried Parents and their Children

Probation and Welfare Service:
Mr David O'Donovan, A/Principal, Probation and Welrare Service, Department of Justice

Garda Siochana:
Inspector Mary Fitzgerald

Co-option:
Mr Robbie Gilligan, Social Studies Department, Trinity College

TEENAGE PREGNANCY/ADOPTION - SUB-COMMITTEE REPORT

The committee was given the task of making proposals in relation to the prevention of teenage pregnancy, supports to teen parents and also to consider issues in relation to adoption.

A number of issues were identified in relation to adoption which necessitated considerable discussion e.g. lack of post adoption supports, adequacy of procedures for selecting adoptive parents, particularly in the past, which has given rise to an over representation of adult adoptees attending die psychological services, etc but time did not permit discussion to the extent desirable.

The committee focused on the issue of teenage pregnancy. Despite a reduction in numbers the committee believes that greater efforts should be made to ensure the numbers are reduced even further. It is acknowledged that a great deal of misinformation abounds on numbers and trends.

The brief submission is broken down as follows:

- Trends in relation to teenage pregnancy and
- Recommendations on prevention and support

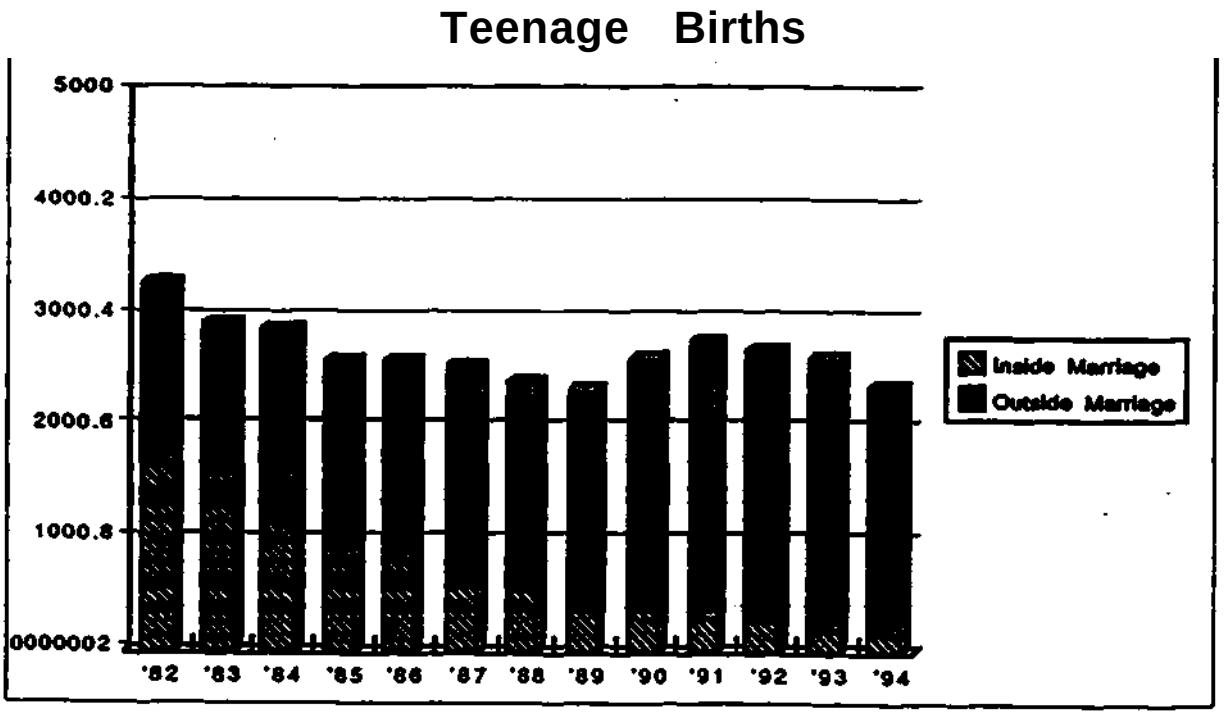
TRENDS

Significant changes have taken place in teenage pregnancies in the past 10-15 years

Pregnant teenagers are not marrying because of pregnancy, and

The vast majority of unmarried teenage mothers now keep their babies whereas in the past they placed them for adoption.

As the following chart shows when both marital and non-marital teenage births are combined and viewed in the same context, the overall picture of teenage births is one of decline. There were 2,903 births to teenagers in 1984 and in 1994 the number had dropped to 2,376. In 1984, however, 60% of teenage births were to non-married teenagers and by 1994 93% were to non-married's. This is perhaps partly explained by the change in attitude on the part of parents in not pushing men-children into hurried marriages and me change in the preparation and counselling arrangements for Catholic marriages.



Treoir/CSO

The committee generally agreed that marriage because of pregnancy is not desirable and that research indicates mat marriages which take place to teenagers, particularly pregnant teenagers, are more likely to end in separation than other marriages.

RECOMMENDATIONS

The Eastern Health Board should concern itself with the issue of teenage pregnancy generally, irrespective of marital status of parents.

Following a great deal of discussion and deliberation the Committee proposes die following recommendations:

1. Education is a key factor in die area ofprevention and teenagers should be encouraged to remain in education for as long as possible. Emphasis on training for employment and job availability are key issues. It has been shown that attitudes to early pregnancy among teenagers in more affluent areas are quite different to those living in areas of deprivation. Careers and independence are seen as apriority and motherhood is not considered an option.

2. Tht F.HR ghmilri appoint a mmmitf«» tn liaise with the Department nf Education on initiating personal development programmes which would also incorporate life skills, sexuality etc.

3. The Department of Education should be asked to incorporate the best elements of useful preventive projects - Teenage Health Promotion Programme piloted successfully in Community Care Area 8 and now extended to Areas 1,2 and 7, Primary Prevention Programme developed in Community Care Area 5, into its programmes. A somewhat similar programme which was devised by the Department of Child Health in the University of Exeter was evaluated and found that the intervention programme was successful in reducing the number of teenage pregnancies. The programmes should be taught to boys as well as girls.

4. Better liaison and co-operation between the community care teams, the maternity hospital social workers and voluntary agencies providing services to unmarried parents is essential in order to ensure that adequate counselling and supports are available to pregnant teenagers and young unmarried parents.

   Ideally social workers should discuss with pregnant teenagers all the options open to mem, however, cogniscence must be taken of the difficulties of discussing adoption with some families because of cultural and principled objections to "giving up" a baby.

5. Combined ante-natal care (G.P's and Hospital) should be promoted for young modiers to ensure continuity of care. Mechanisms need to be developed to improve liaison between Maternity Hospitals and Community Care Services, particularly in relation to notification of births and ante and post natal supports.

6. Family Planning Clinics should be user friendly for teenagers. The issue of availability of contraceptives to teenagers who are sexually active must be addressed.

7. Teenage ante natal clinics should be developed at local health centres. Follow on parenting classes should also be developed so mat young teenage mothers and fathers leam to care and manage their own health and learn parenting skills.

8. Professionals should recognise the importance to children of having a relationship with bom parents and young couples should be helped to co-parent their children even if they do not live together.

9. Immediate steps should be taken to implement the proposal for a pilot project to test a new approach to Early Childhood Programmes in Disadvantaged Communities which was recommended by the Child Care Advisory Committee in 1994. (Attached for easy reference).

Pilot Project

Proposal to test a new approach to Early Childhood Programmes in Disadvantaged Communities

Introduction

The following is a proposal for the launch of new approach to the delivery of health and social support to vulnerable parents and young children in a district of high social stress in the Board's area. The proposed programme embraces a range of elements which would offer a new level of care and support to mother (and rather) and child from pregnancy right through to the child starting school It is considered that a comprehensive and integrated approach of this kind to the needs of these fmnilies can produce important healm and social gains at the level of the child, the parents and the community. This proposal is strongly rooted in the Board's tradition of special programmes to support vulnerable groups, eg. the Community Mothers Programme, the special mobile clinic for travellers etc.

Health and social support ante natally is very important for the vulnerable (in terms of social stress) mother. But mothers who are at high risk socially are, classically, difficult to reach. There is a need, therefore, to try out as many imaginative and innovative outreach approaches as possible in order to attract tihese women to use the services early for the benefit of their own health and that of their child - to - be.

The period around birth and the early months can set the pattern for long term maternal attitudes towards, and relationships with, the new child. Therefore it represents a key time for intervention, in that intervention in this period may offer a very high return on investment in terms of preventive effects. Effort invested at this time may help mother to avoid reactivating any destructive patterns which she may have experienced in her upbringing.

Family and social experiences in the pre-school years are known to have a powerful influence on the child's emotional, social and cognitive development and on the child's readiness to gain and grow through the social and educational experience offered by school.

Key issues for mother of young child in terms of child welfare are

(i) Importance of access to social support for mother. This support may be formal in character (that is provided by professionals or organised services) or it may be informal (that is provided by family, neighbours, friends). From whatever source, support, according to the available research, is found to be particularly effective in situations of high social stress;

(ii) importance of mother developing a bond to the child. This means in lay terms that the woman is 'cracked' about her child and that this keeps her going even through the hard times when the child is sick, difficult or demanding and outer things are also going wrong in her life.

(iii) importance of supportive relationship and active help from the partner/father of child

(iv) importance of access to practical help, day care, respite care when sick or exhausted etc.

(v) importance of mother having realistic view/expectations/understanding about child's developmental stages/needs

(vi) importance of recognition of the fact that high social stress is damaging for the child, the mother and their relationship. Impact of multiple stress operates cumulatively in a multiplier rather than additive way.

(vii) importance of recognition of the fact that maternal depression is very common in mothers of young children. Maternal dcpression is damaging to the mother-child relationship and can persist if not recognised and properly treated.

Lessons for services:

(i) The importance of a comprehensive approach addressing the child's needs and the mother's needs - day care and home visiting and support groups and information/education and personal development

(ii) The need for different approaches at different ages (of child) and in different social

(iii) The need for integrated approach (Le. tightly co-ordinating different services/professionals)

(iv) The need for services to address needs of the parents as parents and as adults, mat is support to mothers should also offer them support as women, since if at least some of their social and psychological support needs as *women* can be met then as mothers they will be better able to respond to the needs of the child.

(v) The need to prioritise certain potentially high risk groups because of the extra possible disadvantages associated with their status/condition (e.g.)

*teen parents
*low income lone parents (living alone), especially in areas of serious social disadvantage
*travellers
*mothers suffering from depression

Outline Proposal

What is proposed is a Pilot scheme which would try to build on the lessons of experience and the messages from research about the needs of vulnerable young families.

It would aim to offer a guaranteed comprehensive range of supports of the types mentioned above to all mothers in a selected high social stress district It is envisaged that the Project would be led by EHB but with support from a range of possible sources/partners, viz. Combat Poverty, Van Leer, FAS, EC Urban Programme, ADM programmes, Department of Education Earlystart programme etc.

The Project would include:

(i) intensive PHN/Community Mother support ante - peri - and post - natally;

(ii) close involvement by maternity hospital outreach;

(iii) active outreach to fathers;

(iv) support groups for pregnant women and new mothers;

(v) nutritional and other active health information schemes for pregnant women and new mothers;

(vi) mother and baby/toddler clubs;

(vii) personal development course for parents- as adults rather than only in relation to their parental role;

(viii) adult education, skill development, return to work courses for parents;

(ix) good quality creche/child minding facilities for these courses:

(x) guaranteed high quality day care places for all young children over an agreed age from local area;

(xi) extra GP input

The Project would be led by a Project Director who would lead a multi-disciplinary team of health board personnel. Main costs would be day care and director, since existing services could make much of the contribution.

The aim of me project is to use a comprehensive preventive programme to alter in a positive way the destinies socially and economically the lives of the children born to participating parents, the lives of those parents and the life and fabric of a community which otherwise seems doomed to further economic and social decline. In this positive way, the health prospects of those affected can quite literally be transformed. This is a project with potential to offer high health and social gain on a relatively modest investment What is required is not so much a large investment of money, but the vision for desired change and the political skill to secure the co-operation of the relevant other services/agencies and the Board's own professionals.

13th December 1994

Children in Care - Sub-Committee Report

Introduction

The Committee acknowledges and welcomes the introduction of the new Child Care (Placement of Children in Residential Care) Regulations 1995; Child Care (Placement of Children in Foster Care Regulations) 1995 and Child Care (Placement of Children with Relatives Regulations) 1995.

Being in care can mean either foster care, being placed with relatives or in residential care; public care is in reality a substitute for private care within families. The common factor to all children in care is mat they are in public care and that parenting tasks are divided amongst various agencies, people and institutions. There are inherent difficulties in the provision of care. If services are to work better, certain things need to be in place and it is hoped that mis report will help to highlight the main issues involved. There are huge implications for children in care from the perspective of the children themselves, their families parents, the statutory and voluntary bodies providing the services and in the arena of public policies. One factor that underlines all children in public care is that what is traditionally seen as private - family life - has been disrupted and me family has been opened to public scrutiny.

The fact that these children are in public care is in some respect misleading as there has been very little debate about what happens to children in such public care. At times this can manifest itself in community reluctance to have children homes in their area. Often the parents are seen as "bad irresponsible and as such find themselves polarised from 'good' parents.**

Good planning is essential and both children and families need to be involved alongside social workers, foster families and child care workers in the decision making process. It is well documented in research that children can drift in care unless there is effective planning which may mean returning the child or planning for it's long term needs from an early date. Effective assessment identification of needs and planning to meet these must be in place. Structures must be in place to provide supervision which improves decision making.

Services for children must be based on need and these identified needs must be matched. Obviously there is a dilemma for professionals if these needs cannot be met Often this is the basic question of social workers who are faced with decision making for children is care better than children remaining at home? This is the key issue feeing all of us who are planning and providing services for children and young people who are very vulnerable.

Reception into care

It is useful to start at the whole issue of reception into care. We need to be aware of the reasons why a child is admitted to care. It is important to recognise the multi-facetedness of the factors leading to a child's reception into care. Services to prevent admission to care should be in place in each area. It is well documented that children are more likely to remain in care if they are not returned home within 6 weeks. This must mean that this period is of paramount importance to the services that are provided to the child and the family to effect a resolution of how the identified factors that have led to the difficulties are changed i.e. what needs to be changed and how this is done for the child and family. Of course, this has clear implications for involving families and children in the process of identifying, clarifying and working on the issues.

Recommendation: Early intervention services which will prevent admission to care should be in place in each area.

Planning for children in care

The new Regulations stipulate that a detailed care plan should be drawn up for each child upon admission to care. This should be done in conjunction with the child, the child's family, foster parents/ residential care staff. Many issues have to be addressed, medical, educational and psychological. All these need to be assessed and the appropriate services found. Gaps in educational provision for children in care should be examine - for example some care facilities require on-site education. There is also a need for access to psychiatric, psychological and therapeutic services. The DHSS Guidance and Regulations regarding admission to care remind us that: *"Patterns of working and attitudes established now will in most cases influence all future work".* (p48) Very detailed guidance to the content of care plans is given in the DHSS document and these are attached in Appendix One.

Recommendation: The Committee recommends that fall support be provided by the Health Board to social work teams, carers and residential care agencies in **drawing up and implementing detailed care plans as outlined in the regulations. In consultation with the Department of Education, the Board should review the education needs of children in care.**

Access

Retention of links with the family where at all possible is essential for the wellbeing of children in care. The continuing role of the parent in the life of the child is crucial and should be emphasised where possible at all times. Access (or contact between the parents and child) is associated with earlier discharge from care and with better adjustment in social, emotional, psychological and cognitive development

Recommendation: The Committee recommends that residential care agencies and those with responsibility for foster care, should review the access arrangements of children in care. In the light of the new Regulations, these arrangements should allow for access to be as flexible and as frequent as the wellbeing of the child allows. If access cannot occur in the child's own home, it should take place in surroundings which are as relaxed and as home-like as possible.

Reviews

Along with adequate planning^ a system of reviews of each child in care is important in order to prevent a child drifting in care. Attention is drawn to the requirements in this regard of Child Care (Placement of Children in Residential Care) Regulations 1995 and Child Care (Placement of Children in Foster Care) 1995 and mat reviews of children in care should take place accordingly.

Recommendation: The Committee recommends that adequate and planned reviews of children in care should take place in accordance with the regulations and that sufficient resources are made available to facilitate this.

Aftercare

After care needs to be planned for probably at the point of reception into care. Children and young people need preparation for leaving care and coping with adulthood and independent living skills should be fostered as much as possible. The discharge cut-off is sometimes seen as age related and other factors such as educational requirements, disability issues and ability to manage oneself are important It is considered desirable that a designated person is appointed to undertake aftercare tasks.

Recommendation: The Committee recommends that care plans for children should include arrangements for reunification or adequate aftercare. **Residential care agencies should examine if the allocation of a staff member to undertake this role in each group home is possible.**

Carers and Care Staff: recruitment and training

The impact of looking after children and young people who have experienced loss, separation or abuse is very high on staff and foster carers. Since children require continuity of quality care, this needs to be recognised in the status accorded to the role which they play. Residential care agencies should have sound recruitment procedures; including the exhaustive checking of references of staff by personal contact

Basic professional training for staff should include the acquisition of the knowledge, skills and attitudes required to competently undertake the task of caring for children. Ongoing training and support are also essential and are integral to the provision of a care service. Inservice training should be provided along with professional supervision of staff. Needs which should be addressed include working with children who have difficulty with anger control or whose behaviour generally reflects their troubled past Residential care agencies should explore the provision of the services of staff consultants who can act as a resource for staff in meeting the needs of the children in their care.

With regard to difficulties experienced in recruiting foster parents, consideration should be given to undertaking market research and imaginative recruitment ideas in order to increase participation in fostering. Foster parents who work with challenging children should be supported by professionals and peer support from experienced foster parents. Regular training should be provided for foster parents and participation in training should be a requirement for continuing as a foster parent Adequate respite should be available to foster parents who care for children with acute behavioural difficulties. Linkages should be developed between foster parents and "best-practice" group homes in order to provide support for foster parents.

Recommendations: The Department of Health should be requested to ensure that the training and education of care workers be standardised nationally and that it reflects the skill and knowledge requirements of modern residential care. Adequate inservice training shoukl be provided for managers and staff of group homes. The provision of staff consultants to group homes should be explored. Research into, and improved initiatives for the recruitment of foster parents should take place. Adequate training, professional and peer support should be provided for foster parents and sufficient respite should also be available. Linkages should be formed between foster parents and "best-practice" group homes.

Children's Rights

There needs to be clear policies concerning children in care. This is a broad topic and could be addressed by clarification of the rights of children in care. Policies about abuse in care need to be clear. Children, young people and their families need access to complain and these need to be responded to in an open manner. With regard to the whole issue of child protection and in line with the "An Abuse of Trust" report the recommendations in the appendix are noteworthy. Issues that are problematical concern the question of substance abuse by children/young people in care settings, the placement of known and alleged abusers. Policies around these areas need to be formulated. Anti-discrimination policies regarding ethnic, cultural, religious and sexual orientation must be in place.

Recommendation: The Committee recommends that children's rights while in care should be clarified. Complaints procedures should be drawn up by each residential care agency and should be brought *to* **the attention of the parents and the child.**

Research and Planning

Services must be planned and integrated. We need to look at the needs of children and young people coming into care. What are their needs, how can the existing services meet these needs? We need to identify existing gaps in services and plan to meet these. Foster care and residential care are inter-connected and this needs to be recognised in the integration of services as most children in care experience both. The planning at agency level often mirrors the planning that is done with the carers young persons and their families. Often in child care we are faced with complex issues and dilemmas where easy 'solutions' are not the norm. Perhaps if we can grasp tins, our services would be organised in a more effective way.

Research regarding care should therefore have several facets. In the first instance, the Committee wishes to draw attention to the recommendation in this regard contained in the Review of Adequacy of Child Care and Family Support Services in 1994. This Review recommended tiiat a task force on care placement needs be established in order to give direction and impetus to developments in caring for children. In addition, management information would be obtained so tiiat planned allocation of resources in the coming years can take place. The Committee applauds the initiatives of the Board in establishing Special Care Units; it is recommended that the repertoire of care settings should include adequate numbers of places for disruptive young people.

We also need to look at the profile of the children in care e.g. age, sex, age at admission, legal status on admission to determine what, if any, patterns emerge. It is also significant to study the initial placement patterns of children and a question

that is raised is to what extent age or route mediates initial placement choice. This may be determined by the health board policy at this point in time e.g. there is an expectation that younger children will be fostered.

It is important to look at the careers of children in care, placement patterns, length of stay and history of care. Information is required on the numbers of placements which break down and the characteristics of those which do.

Research is required also on children's experience of care.

While we clearly need to analyse the current figures and patterns of children in care we need to be careful about how we do this and what information we are given. "We need to examine the way that we structure that information and examine the implication for our approach and services". (David Berridge) The information that is gained from such research will mean effective planning for services and will influence and underpin decisions around recruitment of foster carers and the types of residential care that is required.

With regard to foster care, information is required regarding the age profile of carers, length of service, reasons for drop-out (if appropriate) and their views regarding morale, natural family contact, support received, training needs etc

Recommendations: The Committee recommends that a task force into the care needs of the region be established. It is also recommended that research be undertaken to achieve ~~adequate~~ data on the care patterns of children in the region including reasons for admission to care. Research should be undertaken on children's experience of being in care. A profile of foster carers in the region should be established.

Some background information

Children in care represent a significant user of resources in Health Boards. Specifically in the Eastern Health Board the following statistics give me broad canvas which forms the background picture.

The figures of children in care in the Eastern Health Board in 1994 are:

- Total number of children in care: 1,285
- Total number in residential care: 295
- Total number in foster care at 30/9/94: 990 in all forms of foster care.
- Total cost of residential care: £8m approx .

Total cost of foster care 1994: £1.8m

Hidden costs involved in care includes social work time, medical time and education costs. The cost to the child and family is much more difficult to quantify and measure.

Conclusion

Care is costly - to the child, young person, their family, to staff and carers. It is a complex issue that places high demands on agencies and staff. It needs to be enshrined in clear policies and philosophies. This needs to be done at agency and institutional and individual level.

SUMMARY OF RECOMMENDATIONS

The Committee recommends that:

Early intervention services which will prevent admission to care should be in place in each area.

Full support be provided by the Health Board to social work teams, carers and residential care agencies in drawing up and implementing detailed care plans as outlined in the Regulations. Such plans should be drawn up in consultation with the parents and the child.

In consultation with the Department of Education, the Board should review the education needs of children in care.

Residential care agencies and those with responsibility for foster care, should review the access arrangements of children in care. In the light of the new Regulations these arrangements should allow for access to be as flexible and as frequent as the wellbeing of the child allows. If access cannot occur in the child's own home, it should take place in surroundings which are as relaxed and as home-like as possible.

Adequate and planned reviews of children in care should take place in accordance with the Regulations and sufficient resources should be made available to facilitate this.

Care plans for children should include arrangements for reunification or adequate aftercare. Residential care agencies should examine if the allocation of a staff member to undertake this role in each group home is possible.

The Department of Health should be requested to ensure that the training and education of care workers be standardised nationally and that it reflects the skill and knowledge requirements of modern residential care.

Adequate inservice training should be provided for managers and staff of group homes.

The provision of staff consultants to group homes should be explored.

Research into, and improved initiatives for the recruitment of foster parents should take place.

Adequate training, professional and peer support should be provided for foster parents and sufficient respite should also be available.

Linkages should be formed between foster parents and "best-practice" group homes.

Children's rights while in care should be clarified. Complaints procedures should be drawn up by each residential care agency and should be brought to the attention of the parents and the child.

A task force into the care needs of the region be established.

Research be undertaken to achieve adequate data on the care patterns of children in the region including reasons for admission to care.

Research should be undertaken on children's experience of being in care.

A profile of foster carers in the region should be established.

Appendix One

According to the DHSS, a care plan should include:

- the child's identified need (including education and health)
- how those needs might be met
- aim of plan and timescale
- proposed placement
- other services to be provided
- arrangements for contact and reunification
- support in the placement
- likely duration of placement
- contingency plan, if placement breaks down
- arrangements for ending the placement (if voluntary)
- specific details of the parents' role in day to day arrangements
- arrangements for input by parents, the child and others into the ongoing decision-making process
- arrangements for health care
- arrangement for education
- dates of reviews

Source: The Children Act 1989: Guidance and Regulations; Volume 4; Residential Care. London; HMSO.

Appendix Two

1. Agencies providing services to children or vulnerable adults should ensure that culture of openness - trust is fostered within the organisation in which staff can share any concerns about the conduct of colleagues and be assured that these will be received in a sensitive manner. (9)

2. Staff should be encouraged through formal and informal channels of communication to question, express concerns or pass on significant information to management regarding the protection of children or vulnerable adults. (10)

3. Agencies providing services to children are vulnerable adults should ensure that staff who report significant information receive a written acknowledgement of their concerns and confirmation that the organisation has taken appropriate action. (11)

4. Organisations providing services to children or vulnerable adults should ensure that all allegations of sexual misconduct are pursued and their outcomes recorded regardless of the availability of the alleged perpetrator to co-operate with the process of enquiry. (12)

5. Organisations working with children should establish child protection policies and procedures which ensure that all allegations of child abuse are reported to a responsible authority. (38)

6. "Organisations working with children should ensure that staff and volunteers understand their role within the organisation and are familiar with written guidance on the child protection policies of the agency". (41)

7. Organisations should establish procedures for supervisory and monitoring the activity of staff. (42)

8. All staff and volunteers working with children should have access to child protection training. (43)

9. Organisations working with children should provide children and their parents with brief written information about the activities of the organisation, its child protection policy and the name of a person to contact in the event of any concerns. (48)

Source: "An Abuse of Trust". The report of the Social Services Inspectorate Investigation into the case of Martin Huston 1993

EASTERN HEALTH BOARD

Report no. 47/1995

Drug Services - Development Plans for 1996

A detailed progress report on our Board's drug services in 1995 was circulated for the information of members at the November meeting of our Board.

The further development of existing services and the development of new services will be contingent on a number of factors:-

[i] the early completion of the planning process for the development of further services in a number of locations which is currently under way

[ii] the enhancement of the existing range of service options e.g. implementation of the G.P. protocol

[iii] the level of development funding available

We have had a number of discussions with representatives of the Department of Health regarding current service requirements and proposals aimed at enhancing our current services and providing services in a number of areas where no local service exists at present The Department's response to our submissions in this regard is currently awaited, following which a detailed report will be brought to our Board concerning drug services for 19%.

13th December, 1995

KJ. Hickey,
Chief Executive Officer.